3 Aged and Disabled Guidelines

3.1 Introduction

3.1.1 Overview

Idaho's elderly and disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the person's own home and/or community regardless of age, income, or ability. These services should encourage the involvement of natural supports such as family, friends, neighbors, volunteers, religious community, and others. The Department of Health and Welfare's Medicaid Program requested and obtained a Home and Community-Based Services (HCBS) waiver from the federal government. In October 2006, the Traumatic Brain Injury Waiver (TBI) services were combined into the A & D waiver.

The HCBS waiver allows the provision of services that may be provided in a number of community living situations, such as:

- The person's own home or apartment.
- The home of relatives who are the primary non-paid care providers\certified family homes.
- Residential care facilities.
- Assisted living facilities.

This section covers all Medicaid services provided through Waiver Services for Aged and Disabled (A&D) Waiver as deemed appropriate by the Department of Health and Welfare (DHW) including:

- Adult day care.
- Adult residential care.
- Non-medical transportation.
- Specialized medical equipment and supplies.
- Attendant care.
- Psychiatric consultation services.
- Service Coordination.
- Chore services.
- Companion services.
- Consultation services.
- Homemaker services.
- Home delivered meal services.
- Environmental accessibility adaptations.
- Respite care services.
- Nursing services.
- Personal emergency response system services.
- Supported Employment.
- Day Habilitation.
- Residential Habilitation.
- Behavior Consultation/Crisis Management.

Note: Aged and Disabled Waivers are covered for Medicaid Enhanced Plan participants.

3.1.1.1 Regional Medicaid Services

In order to better serve the public, the state is organized into seven regions to provide programs that foster a productive, healthful, and independent quality of life for Idaho citizens. Each region serves several counties.

Regional Medicaid Services (RMS) is a unit of the Division of Medicaid in the region that acts as the administrative case manager for the Aged and Disabled Waiver. They determine unmet needs through the Uniform Assessment Instrument (UAI), authorize waiver services, and develop an Individual Service Plan (ISP).

3.1.2 General Information

This section covers all general claim information for waiver services for aged and disabled adults (A&D Waiver).

It addresses the following:

- Provider qualifications.
- Record keeping.
- Participant eligibility.
- Prior authorization (PA).
- Billing information.
- Place of service delivery and exclusions.
- Plan for Services.
- Change of provider information.

3.1.2.1 Provider Qualifications

All providers of services must have a valid provider agreement or performance contract with Medicaid. Providers must meet the qualifications of *IDAPA 16.10.329 Aged Or Disabled Waiver Services – Provider Qualifications And Duties*. The RMS in each region will monitor performance under this agreement or contract.

Attendant care, respite, companions, and other waiver service providers must obtain a separate provider number for transportation services.

Non-Medical Transportation Services providers must be enrolled as transportation vendors with the Idaho Medicaid program; see *Section 3.4 Non-Medical Transportation,* for more information.

Specialized Medical Equipment and Supplies Services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see *Section 3.5 Specialized Medical Equipment and Supplies,* for more information.

Environmental Accessibility Adaptation providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see *Section 3.14 Environmental Accessibility Adaptation,* for more information.

Personal Emergency Response System Services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see *Section 3.17 Personal Emergency Response System (PERS) Services,* for more information.

Supported Employment, Residential Habilitation, and Day Habilitation providers must be enrolled as a Traumatic Brain Injury (TBI) provider with the additional TBI Provider Agreement.

3.1.2.2 Record Keeping

Medicaid requires all providers to meet the documentation requirements listed in the Provider Enrollment Agreement and IDAPA rules. Providers must generate records at the time of service and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. Providers must also retain all medical records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

3.1.2.3 Participant Eligibility

For a participant to be eligible for Medicaid payment of waiver services, the RMS must determine that all of the following criteria are met:

- The participant requires services due to a physical or cognitive disability, which results in a significant impairment in functional independence as demonstrated by the findings of a UAI.
- The participant is capable of being maintained safely and effectively in a non-institutional setting
- The participant would need to reside in a nursing facility in the absence of waiver services; Medicaid Program expenditures for the care of the person in the community will be no more than the Medicaid Program costs would be for that person's care in a nursing facility.

3.1.2.4 Prior Authorization (PA)

RMS must authorize all services reimbursed by Medicaid under the A&D Waiver Program before services are rendered. Approved PAs are valid for one year from the date of prior authorization by the RMS unless otherwise indicated.

The PA number must be included on all claims or they will be denied. Exception: providers billing code **S5140-U2** (Adult Residential Care) do not need to include the PA number on the claim.

See *Section 2.3 Prior Authorization (PA)* in the *General Billing Information Guidelines,* for additional billing information.

3.1.2.5 Healthy Connections (HC)

HC referrals are not required for services under the A&D Waiver.

3.1.2.6 Place of Service (POS) Delivery and Exclusions

Participants may choose to receive A&D Waiver services in the following environments:

- Participant's own home or apartment.
- Certified Family Home.
- Residence of the participant's family.
- Day care.
- Residential Care and Assisted Living Facilities.
- The community.

The following living situations are specifically excluded as a personal residence for A&D waiver services:

- Licensed, skilled, or intermediate care facility.
- Certified nursing facility (NF) or hospital.
- Licensed intermediate care facility for the mentally retarded (ICF/MR).

3.1.2.7 Individual Service Plan (ISP)

All services must be prior authorized by the RMS in the region where the participant resides. The services must be based on a written Individual Service Plan (ISP).

The RMS or its contractor and the participant develop the ISP for the A&D Waiver. In addition, the following persons may be included:

- The PCS service coordinator or RN Supervisor.
- The guardian, family, or current service providers, unless specifically excluded by the participant.
- Others identified by the participant.

The ISP is based on a person-centered, planning and assessment process using the UAI and the participant's choice of services. It describes the specific types, amounts, frequency, and duration of Medicaid reimbursed services to be provided.

The ISP must include documentation of the participant's choice between waiver services and institutional placement and the participant's or a legal guardian's signature (if applicable).

The ISP must be revised and updated by the RMS based upon significant changes in the participant's needs and be re-authorized at least annually.

The ISP includes all Medicaid allowable services and supports, and all natural or non-paid services and supports. See *IDAPA 16.03.10.329 Aged Or Disabled Waiver Services – Provider Qualifications And Duties,* for supervision requirements for each participant service.

3.1.2.8 Plan of Care (POC)

All services that are provided must be based on a written POC. The POC is developed by the POC team which includes the participant, the family, guardian, service providers, and others identified by the participant.

The POC must be based on the UAI. It will include:

- Type, amount, frequency, and duration of services with the provider identified.
- Support and service needs to be met by the participant's family, friends, other community resources, and the providers of services.
- Goals to be addressed.
- Activities to promote progress, maintain functional skills, or delay or prevent regression.
- The signature of the participant.

The plan must be revised and updated by the POC team based upon treatment results or a change in the participant's needs.

3.1.2.9 Change of Provider Information

Notify EDS Provider Enrollment in writing when there are changes to your status as a provider. Do not indicate changes on a claim form. Include in the written notice your provider name and current Medicaid provider number. Status changes include:

- Change in address.
- New phone number.
- Name change (individual, group practice, etc.).
- Change in ownership.
- Change in tax identification information.
- Additions or deletions to a group or agency.

Use the Change of Address form available in *Appendix D; Forms* and mail to:
EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

3.2 Adult Day Care

3.2.1 Overview

Adult day care is a supervised, structured day program outside of the home of the participant that may offer one or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. All services must be prior authorized by the RMS prior to payment.

Note: Adult day care services are covered for Medicaid Enhanced Plan participants.

3.2.2 Facilities

Facilities that provide adult day care must be maintained in a safe and sanitary manner and meet the requirements of the Adult Day Care Provider Agreement. Facilities will provide the staff and space necessary to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary to assure the comfort and safety of the participants served.

3.2.2.1 Provider Home (Certified Family Home)

Providers accepting participants into their home for services must maintain the home in a safe and sanitary manner and meet the standards of the Adult Day Care Provider Agreement and home certification identified in *IDAPA 16.03.19 Rules Governing Certified Family Homes*. The provider must provide supervision as necessary to assure the comfort and safety of the participants served.

3.2.3 Diagnosis Code

Enter the ICD-9-CM code **V604** – No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.2.4 Place of Service (POS) Codes

Adult Day Care Services can only be provided in the following POS:

12 Home

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.2.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing adult day care services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Adult Day Care	**S5100** **U2** Modifier Required	Day Care Services, Adult 1 Unit = 15 minutes

3.3 Adult Residential Care (ARC)

3.3.1 Overview

Adult Residential Care (ARC) consists of a range of services provided in a congregate setting licensed in accordance with *IDAPA 16.03.22 or IDAPA 16.03.19*. Locations can include: certified family home, assisted living facility, residential care facility, or other facility where care is provided commercially.

The service need identified by the Uniform Assessment Instrument (UAI) is negotiated between the facility and the participant and may include medication management, assistance with activities of daily living, meals (including special diets), housekeeping, laundry, transportation, opportunities for socialization, recreation, and assistance with personal finances. Administrative oversight must be provided for all services provided or available in this setting.

A negotiated service agreement (NSA) will be developed between the participant, or the participant's legal representative, and a facility representative. While in this setting, the participant will not be eligible for other waiver services except for nursing services, consultation, behavior consultation, and assistive technology.

Note: Adult residential care services are covered for Medicaid Enhanced Plan participants.

3.3.2 Provider Qualifications

The facility must meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff is provided to meet the needs of all participants accepted for admission on a 24 hour, seven days per week basis.

3.3.3 Payment

Payment will be made on a *per diem* basis. The daily payment rate will be established by the RMS based on the hours of service established in a NSA and on the findings of the UAI.

3.3.4 Diagnosis Code

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.3.5 Place of Service (POS) Code

Adult residential care services can only be provided in the following POS:

33 Custodial Care Facility (certified family homes, assisted living facilities, residential care facilities, and other living situations where care is furnished commercially)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.3.6 Procedure Code

Use the 5-digit HCPCS procedure code when billing adult residential care services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Adult Residential Care	**S5140** **U2** Modifier Required	Foster Care, Adult 1 Unit = 1 day of service

3.4 Non-Medical Transportation

3.4.1 Overview

Non-medical transportation consists of individual assistance with non-medical transportation services, including an escort for a participant who has difficulties (physical or cognitive), using regular vehicular transportation. The services must be specified in an ISP and POC to enable the participant to gain access to waiver and other community services and resources. This service is in addition to medical transportation services and does not replace them. Waiver transportation is limited to 1,800 miles per year.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized.

Note: Non-medical transportation waivered services are covered for Medicaid Enhanced Plan participants.

3.4.2 Provider Qualifications

Providers of transportation services must possess a valid driver's license, valid vehicle insurance, comply with all applicable state laws, and be enrolled as a Medicaid transportation provider.

3.4.3 Payment

Payment for non-medical waiver transportation is reimbursed at the per-mile rate established by Medicaid. Providers and participants receive a Notice of Decision that identifies the procedure codes that have been approved and are to be used for billing. The PA number must be included on the claim or the claim will be denied.

3.4.4 Diagnosis Code

Enter the ICD-9-CM code **7999** – Other Unknown, as the primary diagnosis code in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.4.5 Place of Service (POS) Code

Non-medical transportation can only be provided in the following POS:

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.4.6 Procedure Code

Use the 5-digit HCPCS procedure code when billing non-medical transportation services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
A&D Non-Medical Transportation	**A0080** **U2** Modifier Required	Non-Emergency Transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest 1 Unit = 1 mile

3.5 Specialized Medical Equipment and Supplies

3.5.1 Overview

Specialized Medical Equipment and Supplies (SME) is any item, piece of equipment or product system beyond the scope of the Idaho Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Specialized Medical Equipment and supplies also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. These services are authorized by the Medicaid DME unit.

Items covered are in addition to any SME furnished under the Idaho Medicaid State Plan and shall exclude those items that are of no direct medical, adaptive, or remedial benefit to the participant. All items must meet applicable standards of manufacture, design, and installation, including Underwriter's Laboratory, Federal Drug Administration (FDA), and Federal Communication Commission (FCC) Standards. Items available under the Medicaid Program may only be billed by a medical vendor provider.

Note: Specialized medical equipment and supplies waiver services are covered for Medicaid Enhanced Plan participants.

Note: Provider responsibilities, payment information, and diagnosis, place of service, and procedure codes can be found in *Section 3 Durable Medical Equipment Guidelines*.

3.5.2 Provider Qualifications

Providers of SME purchased under this service must:

- Be an authorized dealer of equipment that meets Underwriters Laboratory Standards, Federal Drug Administration Standards, or Federal Communication Commission Standards when applicable.
- Must provide the specific product when applicable (i.e. medical supply businesses or organizations that specialize in the design of the equipment).

Specialized medical equipment items over $500.00 require three competitive bids.

3.5.3 Place of Service (POS) Codes

Specialized medical equipment can only be provided in the following POS:

11 Office

12 Home

3.5.4 Procedure Codes

Use the following 5-digit HCPCS procedure codes when billing for SME. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Note: Specialized medical equipment and supplies for A&D waivered services are covered for Medicaid Enhanced Plan participants.

Service	HCPCS	Description
Specialized Medical Equipment	**E1399**	Specialized Medical Equipment, Miscellaneous

3.6 Attendant Care

3.6.1 Overview

Attendant care consists of services that involve personal and medically oriented tasks dealing with the functional needs of the participant. Most care is self-directed by the participant.

These services may include personal tasks and medically related tasks that may be done by unlicensed persons, or delegated to unlicensed persons by a health care professional. In addition, it may include administration of medications, ventilator care, and tube feedings.

Services may occur in the participant's home, community, work, or school settings as authorized in the DHW approved plan for services.

Note: Attendant care for A&D waivered services are covered for Medicaid Enhanced Plan participants.

3.6.2 Provider Qualifications

An employee of an agency or fiscal intermediary must provide services. A provider employed by a fiscal intermediary is selected, trained, and supervised by the participant or participant's family.

3.6.3 Diagnosis Code

Enter the ICD-9-CM code **V604** – No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.6.4 Place of Service (POS) Codes

Attendant care can only be provided in the following POS:

03 School

12 Home

33 Custodial Care Facility (certified family homes, assisted living facilities, residential care facility, and other living situations where care is furnished commercially) when the negotiated service agreement does not identify this service as the responsibility of the facility

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.6.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing attendant care services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Attendant Care	**S5125** **U2** Modifier Required	Attendant Care Services 1 Unit = 15 minutes

3.7 Psychiatric Consultation

3.7.1 Overview

Psychiatric consultation services provide direct consultation and clinical evaluation of participants who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis.

This service may provide training and staff development related to the needs of the participant.

These services also provide emergency back-up involving the direct support of the participant in crisis.

Note: Psychiatric consultation for A&D waivered services are covered for Medicaid Enhanced Plan participants.

3.7.2 Provider Qualifications

Services must be provided by an employee of an agency, fiscal intermediary, or individual. The provider must have one of the following:

- A master's degree in a behavioral science and licensed in accordance with State law to provide psychiatric services.
- A bachelor's degree, work for an agency with direct supervision from a licensed or Ph.D. psychologist, and have one year of experience in treating severe behavior problems.

3.7.3 Diagnosis Code

Enter the ICD-9-CM code **V604 –** No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.7.4 Place of Service (POS) Codes

Psychiatric consultation can only be provided in the following POS:

03 School

11 Office

12 Home

33 Custodial Care Facility (certified family home, assisted living facility, residential care facility or other facility where care is provided commercially)

99 Other (Community, Adult Day Care)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.7.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing psychiatric consultation services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Psychiatric Consultation	**90899** **U2** Modifier Required	Unlisted Psychiatric Service or procedure 1 Unit = 15 minutes

3.8 Service Coordination

3.8.1 Overview

Service coordination is a service designed to foster the independence of the participant by demonstrating to the individual how to best access service delivery systems such as energy, legal, or financial assistance. Service coordination services are delivered by qualified providers to assist Medicaid participants to obtain needed health and social services. Service coordinators must meet the provisions of *IDAPA 16.03.10.720 Service Coordination* through *721 Service Coordination - Definitions.*

Note: Service coordination services are covered for Medicaid Enhanced Plan participants.

3.8.2 Service Delivery

All individual service coordinators must be employees of an organized entity that has a valid provider agreement on file with Idaho Medicaid. Agreements are negotiated and monitored by the Regional Medicaid Services (RMS) unit.

The service coordinator agency cannot provide personal care services and service coordinators services to the same participant.

3.8.2.1 Provider Qualifications

The employing entity will supervise individual service coordinator providers and assure that the following qualifications are met:

- Must be a licensed social worker; or licensed professional nurse (R.N.); or has at least a BA or BS in a human services field and at least one year's experience in service delivery to the service population.
- Must be supervised by an individual who has at least a BA or BS degree and is a licensed social worker, psychologist or licensed professional nurse (registered nurse) with at least two years experience in service delivery to the service population or a masters degree in a human services field and one years experience with the population for which he/she will be supervising services; the supervisor will oversee the service delivery and have the authority and responsibility to remove the individual case manager if the participant's needs are not met.

The service coordination agency must demonstrate:

- Capacity to provide all services.
- Experience with target population.

Appropriate personnel practices, including but not limited to, conducting an orientation program for all new employees that covers at least the local resources available, service coordination service delivery, confidentiality of information, and participant rights.

3.8.3 Service Coordinator's Responsibilities

The service coordinator will have face-to-face contact with the participant at least every 90 days. The frequency, mode of contact, and person being contacted must be identified in the ISP. Service coordination services will consist of assessing the individual's needs and developing and implementing the service coordination plan.

3.8.3.1 Assessing the Participant's Needs

To assess a participant's needs, the service coordinator will conduct a comprehensive evaluation of the participant's ability to function in the community, including but not limited to:

- Medical needs.
- Physical problems and strengths.
- Mental and emotional problems and strengths.

- Physical living environment.
- Vocational and educational needs.
- Financial and social needs.
- Safety and risk factors.
- Legal status.
- Evaluation of the community support system including the involvement of family or significant other persons.

3.8.3.2 Developing and Implementing the Individual Community Support Plan

The Individual Community Support Plan (ICSP) development is based on the information obtained during the participant assessment and input from involved professionals. Service coordinators must update the ICSP as least annually and get continued approval from the RMS, if appropriate. A copy of the current ICSP must be provided to the participant or his/her legal representative.

Service coordinators develop a written plan that covers:

- Problems identified during the assessment.
- Overall goals to be achieved.
- All services and contributions provided by the informal support system, including the actions, if any, taken by the service coordinator to develop the support system.
- Documentation of who has been involved in the service planning, including the participant's involvement.
- Schedule for case management monitoring and reassessment.
- Documentation of unmet needs and service gaps.
- Reference to any formal services arranged, including costs, specific providers, schedules of service initiation, frequency, or anticipated dates of delivery.

3.8.4 Diagnosis Code

Enter the ICD-9-CM code **V604 –** No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.8.5 Place of Service (POS) Codes

Enter the appropriate numeric code in the POS box on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

11 Office

12 Home

99 Other (Community)

3.8.6 Procedure Codes

Service	HCPCS	Description
Service Coordination-	**G9001** **U2** Modifier Required	Coordinated Care Fee, Initial Rate Assessment and ICSP; this is a one-time rate. 1 Unit = ICSP development

Service	HCPCS	Description
Ongoing and emergency service coordination	**G9002** **U2** Modifier Required	Coordinated Care Fee, Maintenance Rate Maximum of eight hours per month unless approved by the RMS Indicate the total number of units billed. 1 Unit = 15 minutes

3.8.7 Prior Authorization (PA)

The RMS must approve the participant for service coordination services and PA all service coordination services including the assessment and service plan development.

3.8.8 Record Requirements

The provider must maintain the following documentation for a five year period:

- Name of the participant.
- Name of agency and person providing service.
- A copy of the assessment and service plan.
- Place of service.
- Date, time, and duration of service.
- Activity record describing the participant or community contact.

3.9 Chore Services

3.9.1 Overview

Chore services consist of intermittent assistance including, but not limited to, yard maintenance, minor home repair, heavy housework, sidewalk maintenance, and trash removal to assist the participant to remain in his or her home.

These services are available only when neither the participant nor any one else in the household is capable of performing the service, and when no other relative, caretaker, landlord, community volunteer, or third party payer is willing or is responsible for their provision.

Chore services are limited to being provided in a home either rented or owned by the participant.

Chore activities include:

- Washing windows.
- Moving heavy furniture.
- Shoveling snow to provide safe access inside and outside the home.
- Chopping firewood when wood is the participant's primary source of heat.
- Tacking down loose rugs and flooring.

Note: Attendant care for A&D waivered services are covered for Medicaid Enhanced Plan participants.

3.9.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary. A provider employed by a fiscal intermediary is selected, trained and supervised by the participant or the participant's family.

3.9.3 Diagnosis Code

Enter the ICD-9-CM code **V604** – No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.9.4 Place of Service (POS) Code

Chore services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.9.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing Chore Services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Chore Services	**S5120** **U2** Modifier Required	Chores Services 1 Unit = 15 minutes

3.10 Companion Services

3.10.1 Overview

Companion services are in-home services provided to insure the safety and well being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond in emergency situations, or other conditions that would require a person on-site. The provider may give voice cueing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living as required. However, the major responsibility is to provide companionship and to be there in case assistance is needed. The service may be intermittent or regular, depending on the needs of the individual.

Note: Companion services are covered for Medicaid Enhanced Plan participants.

3.10.2 Provider Qualifications

An employee of an agency or fiscal intermediary must provide services. A provider employed by a fiscal intermediary is selected, trained, and supervised by the participant or participant's family.

3.10.3 Diagnosis Code

Enter the ICD-9-CM code **V604 –** No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.10.4 Place of Service (POS) Code

Companion services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.10.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing companion services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Companion	**S5135** **U2** Modifier Required	Companion Care, Adult 1 Unit = 15 minutes Limited to $25.00/day

3.11 Consultation Services

3.11.1 Overview

Consultation services are provided by an agency or fiscal intermediary to a participant or family member. The purpose of consultation services to a participant is to increase the skill of the participant or family member as an employer or manager of the participant's care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and family. Services given to the caregiver are for the purpose of understanding the special needs of the participant and the role of the caregiver.

Note: Consultation services are covered for Medicaid Enhanced Plan participants.

3.11.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary who is capable of performing the duties required based on the Plan for Services.

3.11.3 Diagnosis Code

Enter the ICD-9-CM code **V604** – No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.11.4 Place of Service (POS) Codes

Consultation services can only be provided, face-to-face with the participant or family in the following POS:

03 School

11 Office

12 Home

33 Custodial Care Facility (certified family home, assisted living facility, residential care facility, or other facility where care is provided commercially)

99 Other (Community, Adult Day Care)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.11.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing consultation services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Consultation	**S5115** **U2** Modifier Required	Home Care Training – non family 1 Unit = 15 minutes

3.12 Homemaker Services

3.12.1 Overview

Homemaker services assist the participant with light housekeeping, laundry, essential errands, meal preparation, and other light housekeeping duties when there is no one else in the household capable of performing these tasks.

Note: Homemaker services are covered for Medicaid Enhanced Plan participants.

3.12.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary who is capable of performing the duties required based on the Individual Service Plan (ISP).

3.12.3 Diagnosis Code

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.12.4 Place of Service (POS) Code

Homemaker Services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.12.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing homemaker services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Homemaker Services	**S5130** **U2** Modifier Required	Homemaker Service, NOS 1 Unit = 15 minutes

3.13 Home Delivered Meal Services

3.13.1 Overview

Home delivered meal services are designed to promote adequate participant nutrition through the provision and home delivery of one or two meals per day. Home delivered meals are limited to participants who:

- Rent or own their home.
- Are alone for significant parts of the day.
- Have no regular caregiver for extended periods of time.
- Are unable to prepare their own meals.

Note: **Home Delivered Meal** Services are covered for Medicaid Enhanced Plan A&D waiver participants.

3.13.2 Provider Qualifications

Services of home delivered meals under this section may only be provided by an agency capable of supervising the direct service. The agency must meet the following requirements:

- Ensure that each meal meets one third of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council of the National Academy of Sciences.
- Maintain registered dietitian documented review and approval of all menus, menu cycles, and any changes or substitutions.
- Deliver the meals in accordance with the plan for services in a sanitary manner and at the correct temperature for the specific type of food.
- Ensure that the meals are delivered on time.
- Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest USDA Grade for each specific food served.
- Provide documentation of current driver's license for each driver.
- Be licensed and inspected as a food establishment by the District Health Department.

3.13.3 Diagnosis Code

Enter the ICD-9-CM code **V604 -** No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.13.4 Place of Service (POS) Code

Home delivered meals services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.13.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing home delivered meal services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Home Delivered Meals	**S5170** **U2** Modifier Required	Home Delivered Meals, including preparation 1 Unit = 1 meal

3.14 Environmental Accessibility Adaptations

3.14.1 Overview

Environmental accessibility adaptations services consist of minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization.

Such adaptations may include:

- Installation of ramps and lifts.
- Widening of doorways.
- Modification of bathroom facilities.
- Installation of electrical or plumbing systems which are necessary to accommodate the medical equipment necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning.

Environmental modification services must be completed with a permit or other applicable requirements of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes.

Permanent modifications are limited to a home owned by the participant or the participant's family when the home is the participant's primary residence. Portable or non-stationary modifications may be made when such modification can follow the participant to his or her next place of residence or be turned over to DHW.

Note: Environmental modification services are covered for Medicaid Enhanced Plan participants.

3.14.2 Provider Qualifications

Services must be provided by an individual or business properly licensed or certified to perform the necessary home modifications. Building inspections will be performed as necessary and documentation of the results must be provided to the RMS. Providers must be enrolled as a waiver provider with the Medicaid.

3.14.3 Payment

Payment for environmental accessibility adaptations will be made as prior-authorized by Medicaid. Each item and the allowed payment amount must be authorized. Providers and participants will receive a prior authorization notice, along with a prior authorization number that will identify the procedure codes, items, and the payment amount that have been approved and are to be used for billing.

Note: The PA number must be included on the claim or the claim will be denied.

3.14.4 Diagnosis Code

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.14.5 Place of Service (POS) Code

Environmental accessibility adaptation services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.14.6 Procedure Code

Use the 5-digit HCPCS procedure code when billing Environmental Accessibility Adaptations Services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Environmental Accessibility Adaptations	**S5165** **U2** Modifier Required	Home Modification; per service Environmental Accessibility Adaptations Services, per item and dollar amount as authorized by Medicaid

3.15 In-Home Respite Services

3.15.1 Overview

In-home respite services provide occasional breaks from care-giving responsibilities for non-paid caregivers. The caregiver or participant is responsible for the selection, training, and directing of the provider. While receiving respite care services, the participant cannot receive other duplicate waiver services. Respite care services provided under the waiver will not include room and board payment.

Note: Respite services are covered for Medicaid Enhanced Plan participants.

3.15.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary who is capable of performing the duties required based on the Plan for Services.

3.15.3 Diagnosis Code

Enter the ICD-9-CM code **V604 –** No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.15.4 Place of Service (POS) Code

In-home respite can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.15.5 Procedure Code

Use the 5-digit HCPCS procedure code when billing in-home respite services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
In-Home Respite	**T1005** **U2** Modifier Required	Respite Care Services 1 Unit = 15 minutes

3.16 Nursing Services

3.16.1 Overview

Nursing services consist of intermittent or continuous oversight, training, or skilled care within the scope of the Nurse Practice Act. These services are not appropriate if they are less cost effective than a home health visit. Nursing services may include, but are not limited to:

- Insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material.
- Maintenance of volume ventilators including the associated tracheotomy care and oral pharyngeal suctioning.
- Maintenance and monitoring of I.V. fluids and/or nutritional supplements which are to be administered on a continuous or daily basis.
- Injections.
- Blood glucose monitoring.
- Blood pressure monitoring.

Note: Nursing services for A&D waivered services are covered for Medicaid Enhanced Plan participants.

3.16.2 Provider Qualifications

Nursing services must be provided by a licensed RN, or a LPN under the supervision of a RN who is licensed to practice in Idaho, or be practicing on a federal reservation and be a licensed RN in another state. In addition, they must be an employee of an agency or fiscal intermediary.

3.16.3 Provider Responsibilities

- Evaluate changes of condition.
- Notify the physician and plan monitor immediately of any significant changes in the participant's physical condition or response to the service delivery.
- Provide services in accordance with the nursing plan of care and the waiver plan of service.
- Maintain records of care given to include the date, time of start and end of service delivery, and comments on participant's response to services delivered.
- In the case of an LPN, skilled nursing providers, and other non-licensed direct care providers, document that oversight of services by a RN is in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing.
- An RN can provide either oversight or skilled nursing services.

3.16.4 Nursing Plan of Care

All nursing oversight and skilled nursing services provided must be on a nursing plan of care. The nurse is responsible for the nursing plan of care based upon:

- The nurse's assessment and observation of the participant.
- The orders of the participant's physician.
- The ISP.
- Information elicited from the participant.

The nursing plan of care must include all aspects of the medical care necessary to be performed, including the amount, type and frequency of such services. Certain services can be delegated by an RN.

When nursing services are delegated to a non-licensed provider, the type, amount of supervision and training to be provided must be included in the plan.

3.16.5 Nursing Plan of Care Update

The nursing plan of care must be revised and updated based upon treatment results or as necessary to meet the participant's changing medical needs, but at least annually. A copy of the plan must remain in the participant's home.

3.16.6 Diagnosis Code

Enter the appropriate ICD-9-CM code for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.16.7 Place of Service (POS) Codes

Nursing Services can only be provided in the following POS:

03 School

12 Home

33 Custodial Care Facility, if such services are not included in the negotiated service agreement with the facility

99 Other (Adult Day Care)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.16.8 Procedure Codes

Use the 5-digit HCPCS procedure code when billing Nursing Services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Nursing Services – R.N.	**T1002** **U2** Modifier Required	RN Services 1 Unit = 15 minutes
Aged and Disabled Nursing Service	**T1001** **U2** Modifier Required	Nursing Assessment/Evaluation RN service 1 Unit = 1 visit
Nursing Services – L.P.N.	**T1003** **U2** Modifier Required	LPN/LVN Services 1 Unit = 15 minutes

3.17 Personal Emergency Response System (PERS) Services

3.17.1 Overview

Personal Emergency Response System (PERS) services consists of a system that is provided to monitor participant safety and/or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who meet the following conditions:

- Rent or own their home.
- Are alone for significant parts of the day.
- Have no regular caregiver for extended periods of time.
- Would otherwise require extensive routine supervision.

Note: PERS services are covered for Medicaid Enhanced Plan participants.

3.17.2 Provider Qualifications

Providers must be enrolled as medical equipment vendors in the Idaho Medicaid Program and be able to provide, install, and maintain the necessary equipment and operate a response center capable of responding on a 24 hours, seven days per week basis.

Specific billing instructions can be found in *Section 3 Durable Medical Equipment Guidelines* for medical equipment vendors.

3.17.3 Diagnosis Code

Enter the ICD-9-CM code **V604 -** No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.17.4 Place of Service (POS) Code

PERS can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.17.5 Procedure Codes

Use the 5-digit HCPCS procedure code when billing PERS Services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
System Installation	**S5160** **U2** Modifier Required	Emergency Response System; installation and testing.
Monthly Rent	**S5161** **U2** Modifier Required	Emergency Response System; service fee, per month (excludes installation and testing).

3.18 Behavior Consultation/Crisis Management Services

3.18.1 Overview

Behavior Consultation and Crisis Management (BC/CM) services are services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development to providers related to the needs of a participant. This service requires the provider to meet directly with the participant.

Note: BC/CM services are covered for Medicaid Enhanced Plan participants.

3.18.2 Provider Qualifications

3.18.2.1 Behavior Consultation and Crisis Management (BC/CM) Providers

Providers of this service must work in one of the following situations:

- In a provider agency capable of supervising the direct service.
- Under the direct supervision of a licensed psychologist or Ph.D. in special education with training and experience in treating severe behavioral problems, and training and experience in applied behavioral analysis.
- **P**roviders must have or be one of the following:
- Have a master's degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study.
- Be a licensed pharmacist.
- Have taken a traumatic brain injury training course approved by DHW.

3.18.2.2 Emergency Intervention Technicians

Providers must:

- Meet qualifications of a residential habilitation direct care provider; see *Section 3.1.2.1 Provider Qualifications*.
- Have at least one year of experience working directly with adults with a traumatic brain injury.
- Be supervised by a clinician.

3.18.3 Payment

Medicaid reimburses BC/CM services on a fee-for-service basis. All services must be authorized prior to payment and must be the most cost-effective way to meet the needs of the participant. The RMS authorizes services.

Note: The PA number must be included on the claim or the claim will be denied.

3.18.4 Diagnosis Codes

Enter the ICD–9-CM code **V604 -** No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or the appropriate field on an electronic claim form.

3.18.5 Place of Service (POS) Codes

BC/CM Services can only be billed for the following POS:

11 Office

12 Home

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field on an electronic claim form.

3.18.6 Procedure Codes

All BC/CM claims must use one of the following 5-digit HCPCS or CPT procedure codes with the required modifier when billing. The units must be entered in field **24D** on the CMS-1500 claim form or the appropriate field on an electronic claim form.

Service	HCPCS or CPT Code	Description
Emergency Intervention Technician	**H2011** **U3** Modifier Required	Crisis Intervention Service, per 15 minutes 1 Unit = 15 minutes
Professional Behavior Consultation	**90899** **U3** Modifier Required	Unlisted psychiatric service or procedure 1 Unit = 15 minutes

3.19 Day Rehabilitation Services

3.19.1 Overview

Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Day rehabilitation takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in a participant's Plan of Care (POC). There is a limitation of 30 hours per week.

Day rehabilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the POC. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in employment, therapy, or other settings.

Note: Day rehabilitation services are covered for Medicaid Enhanced Plan participants.

3.19.2 Provider Qualifications

All providers of service must have a valid provider agreement with DHW. The RMS in each region will monitor performance under this agreement. Day rehabilitation providers must have:

- A minimum of two years of experience working directly with persons with a traumatic brain injury.
- Provide documentation of standard licensing specific to their discipline.
- Have taken a traumatic brain injury training course approved by DHW.

3.19.3 Payment

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. All day rehabilitation services must be prior authorized by the RMS before being rendered and must be the most cost-effective way to meet the needs of the participant.

Note: The PA number must be included on the claim or the claim will be denied.

3.19.4 Diagnosis Codes

Enter the appropriate ICD-9-CM code for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.19.5 Place of Service (POS) Codes

Day Rehabilitation Services can only be provided in the following POS:

11 Office

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.19.6 Procedure Codes

Use one of the following 5-digit HCPCS procedure codes and required modifier for all Day Rehabilitation Services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Day Rehabilitation (Individual)	**T2021** Modifier Required **U3**	Day Habilitation, waiver; per 15 minutes The limit of hours for day rehab is 30 hrs/wk for both individual and group or in combination 1 Unit = 15 minutes
Day Rehabilitation (Group) limited to not more than six participants	**T2021** Modifiers Required **U3 HQ**	Day Habilitation, waiver; per 15 minutes 1 Unit = 15 minutes

3.20 Residential Habilitation Services

3.20.1 Overview

Residential Habilitation (RES/HAB) services consist of an integrated array of individually tailored services that assist eligible participants in living successfully in their own home, apartment, with their family, or in a Certified Family Home. Components of RES/HAB include skills training, personal assistance, and habilitation as listed in *IDAPA 16.03.10 Medicaid Enhanced Plan Benefits,* and under *IDAPA 16.04.17 Rules Governing Residential Habilitation Agencies*.

Note: RES/HAB waiver services are covered for Medicaid Enhanced Plan participants.

3.20.2 Personal Assistance Services

Personal assistance services support the participant in daily living activities, household tasks, and other routine activities the participant or primary, unpaid caregivers are unable to accomplish.

3.20.3 Skills Training

Skills training involve teaching participants, family members, substitute caregivers, or a participant's roommates or neighbors to perform activities to enhance participant independence and to carry out or reinforce habilitation training. Skills' training is provided to encourage and accelerate development in independent daily living skills, such as housekeeping, meal preparation, dressing and personal hygiene, taking medication, money management, socialization, mobility, and other therapeutic programs.

3.20.4 Residential Habilitation (RES/HAB) Services

Residential habilitation services are aimed at assisting the participant to acquire, retain or improve his/her ability to reside as independently as possible in the community and maintain the family unity, if appropriate. Residential habilitation services include training in one or more of the following areas:

- Personal direction.
- Money management.
- Daily living skills.
- Socialization.
- Mobility.
- Behavior shaping and management.

3.20.5 Supported Living

Supported living is a type of RES/HAB. Supported living is defined as one, two, or three participants living in their own home or apartment who require staff assistance, or one or two participants who live in the home of a non-paid family member and require staff assistance.

The home is considered to be the participant's own home when it is owned or rented by the participant. The home is defined to be owned or rented by the participant(s) when the mortgage, lease, or rental agreement is held by the participant(s) with supporting documentation of such. When two or three participants share a home or apartment, the staff may also be shared.

3.20.6 Certified Family Home

When RES/HAB is delivered in the home of the provider, the home must be a Certified Family Home (CFH). A CFH is defined in, *IDAPA 16.03.19 Rules Governing Certified Family Homes*:

> A home certified by DHW to provide care to one or two adults, who are unable to reside on their own and require activities of daily living, protection and security, and need encouragement toward independence.

A CFH may be granted an exception to the two resident limit, if approved by RMS. With an approved exception, the CFH may provide care and supervision to three or four residents. These providers are reimbursed to deliver RES/HAB as outlined on the participant's Plan of Service.

3.20.7 Program Coordination

Program coordination is a function under RES/HAB. Program coordination is defined as development, implementation, coordination, and evaluation of personal assistance, habilitation, and skills training provided for the participant as components of RES/HAB developed by a Qualified Mental Retardation Professional (QMRP) and delivered by a Residential Habilitation provider. Agencies providing oversight of RES/HAB must employ a Program Coordinator.

Program coordinators must have the following qualifications:

- Education and experience to meet the criteria established for qualifying as a QMRP for DD and ISSH Waiver participants.
- Experience in writing skills-training programs.
- Skill in individualized strategy development, and implementation to assist the participant in meeting wants and needs within the scope of RES/HAB.

Core functions of the Program Coordinator include the following:

- Face-to-face contact with direct service provider(s) and/or participant regarding oversight, supervision, and provision of RES/HAB.
- Implementation plan development.
- Evaluation, analysis, and/or revision of implementation plans.
- Phone contacts specific to RES/HAB services identified on the Individual Service Plan (ISP).
- Attendance at participant meetings specific to RES/HAB services identified on the ISP.
- Emergency contact specific to RES/HAB services identified on the ISP.

3.20.8 Provider Qualifications

Residential habilitation must be provided by an agency certified by DHW as a RES/HAB services provider under *IDAPA 16.04.17 Rules Governing Residential Habilitation Agencies*, or by a Certified Family Home provider who affiliates with a RES/HAB Agency for oversight, training and quality assurance. Residential habilitation agencies must be capable of supervising the direct services provided.

Residential habilitation providers who provide direct services to participants must meet the following requirements:

- Be at least 18 years of age.
- Have a high school diploma or GED, or demonstrate the ability to provide services according to an ISP.
- Have current CPR and first aid certifications.
- Complete an approved Assistance with Medications course prior to assisting with participant medications.
- Be free from communicable diseases.
- Pass a criminal background check.
- Have documentation of universal precautions training.
- Participate in an orientation program provided by the agency prior to performing services including the purpose and philosophy of services, developmental disability, and human development, service

rules, policies and procedures, proper conduct in relating to participants, and handling of confidential and emergency situations that involve the participant.

- Have appropriate certification or licensure, if required, to perform tasks that require certification or licensure.
- Have taken a traumatic brain injury training course approved by DHW.

3.20.9 Provider Responsibilities

3.20.9.1 Training

The provider agency is responsible for training the direct service provider in general education areas of developmental disability. The provider agency must provide supervision to meet the participant's needs.

A program coordinator must develop skill-training programs. The program coordinator must be employed by the RES/HAB Agency.

Additional training requirements for direct service providers include at a minimum:

- Instructional technology.
- Behavior technology.
- Feeding.
- Communication/sign language.
- Mobility.
- Assistance with the administration of medications.
- Activities of daily living.
- Body mechanics and lifting techniques.
- Housekeeping techniques, and maintenance of a clean, safe, and healthy environment.

3.20.9.2 Record Keeping

A RES/HAB provider must maintain a standardized residential habilitation service record for each participant receiving RES/HAB Services. Residential habilitation agency program coordinators are responsible for establishing a standardized format for record keeping that includes all required information.

A copy of the record is maintained in the participant's home, unless RMS authorizes another site. After every visit, document the following information:

- The date and time of visit; the date is given in MMDDCCYY format:

  Examples:

  02/10/2005; 8:00 a.m. - 11:15 a.m.

  11/24/2005; 10:30 a.m. – 3:15 p.m.

- The length of visit in decimal form.

  Example: A visit of three hours and 15 minutes is entered as 3.25 hours.

- A statement of the participant's response to the services including any changes noted in the participant's condition.
- Any changes in the support plan authorized by the RMS as a result of changes in the participant's condition or skill level.
- The participant's signature on the service record, unless the RMS determines the participant is unable to sign.

3.20.9.3 Records Maintenance

To provide continuity of services, when a participant moves, selects a different provider, or changes service coordinators, all of the foregoing participant records will be delivered to and held by the provider or by the Service Coordination Agency.

When a participant is no longer involved in the waiver services program, copies of all the records are retained by the provider agency as part of the participant's closed record. Provider agencies must retain participant records for those to whom they provide services for five years following the last date of service.

3.20.9.4 Change in Participant Status

It is the responsibility of the RES/HAB provider to notify the service coordinator when there is a significant change in the participant's circumstances including accident, injuries, and health related activities.

3.20.9.5 Change of Provider Information

If the provider has a change of name, address, or telephone number, immediately notify EDS in writing. Indicating updated provider information on a claim form is not acceptable and the appropriate changes cannot be made.

Send corrections to:

EDS
Provider Enrollment
PO Box 23
Boise, ID 83707
Fax (208) 395-2198

3.20.10 Payment

Medicaid reimburses RES/HAB Services on a fee-for-service basis.

3.20.11 Diagnosis Code

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.20.12 Place of Service (POS) Codes

RES/HAB services can only be billed for the following places of service:

12 Home (CFH, participant's own home, or home of unpaid family)

99 Other (Community) This code should only be used when the participant receives hourly supported living to access the community. All other residential habilitation should be coded as 'Home'.

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.20.13 Procedure Codes

Bill all RES/HAB claims using one of the following 5-digit HCPCS procedure codes. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.20.13.1 TBI Supported Living Codes

Service	HCPCS	Description
Supported Living - Agency Two Participants	**H2015** Modifiers Required **U3 HQ**	Comprehensive Community Support Services, per 15 minutes Supported living for two participants who live in their own home/apartment or with a non-paid caregiver 1 Unit = 15 minutes

Service	HCPCS	Description
Supported Living - Agency One Participant	**H2015** Modifier Required **U3**	Comprehensive Community Support Services; per 15 minutes Supported living for one participant who lives in his/her own home/apartment or with a non-paid caregiver 1 Unit = 15 minutes
Independent Residential Rehabilitation Program Coordinator	**0930T**	Independent Residential Habilitation Program Coordinator 1 Unit = 15 minutes Limited to 27 units per month **Note:** May only be billed if there is not an agency available in the participant's geographic location This code remains unchanged
TBI Daily Rate (Bundled) One Provider, One or Two Participants; or Two Providers with Two Participants	**H2016** Modifier Required **U3**	Comprehensive Community Support Services, *per diem* 1 Unit = 1 day (Bundled Care) This code is subject to FICA and State withholding by DHW on behalf of the participant

3.20.13.2 Billing Restrictions

Hourly procedure codes cannot be billed on the same date of service as daily procedure codes.

3.21 Supported Employment Services

3.21.1 Overview

Supported employment is competitive work in an integrated work setting for participants with the most severe disabilities for whom competitive employment has not traditionally occurred. Supported employment is also available for participants when competitive employment is interrupted or intermittent as a result of a severe disability. It assists participants who, because of the nature and severity of their disability, need intensive supported employment services, or extended services in order to perform such work.

Supported employment does not include services provided by the Idaho Division of Vocational Rehabilitation (IDVR) such as evaluation, work adjustment, and job site selection.

Note: Supported employment waiver services are covered for Medicaid Enhanced Plan participants.

3.21.2 Provider Qualifications

Supported employment services must be provided by an agency that is capable of:

- Supervising the direct service.
- Meeting accreditation standards of the Commission on Accreditation of Rehabilitation Facilities or Rehabilitation Services Accreditation System, Accreditation Council, or other comparable standard.
- Meeting requirements to be a Medicaid provider.
- Meet the requirements in *IDAPA 16.03.10.329*.

3.21.3 Provider Responsibilities

The provider is responsible for supported employment services, including long-term maintenance or job coaching to support the participant at work.

3.21.4 Payment

Medicaid reimburses services on a fee-for-service basis.

3.21.5 Diagnosis Codes

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.21.6 Place of Service (POS) Code

Supported Employment Services can only be billed in the following POS:

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.21.7 Procedure Codes

Use the following 5-digit HCPCS procedure code when billing Supported Employment Services. Enter this information in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Supported Employment	**H2023** Modifier Required **U3**	Supported Employment, per 15 minutes Maximum allowable – 160 units per week. 1 Unit = 15 minutes

3.22 Claim Billing

3.22.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.22.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission* for more information.

3.22.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a Healthy Connections (HC) participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior authorization (PA) numbers: Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 of the Physician's Guidelines* for more information.

Electronic crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.22.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006

3.22.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form
- Print legibly using black ink or use a typewriter
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field
- Keep claim form clean; use correction tape to cover errors
- Enter all dates using the month, day, century, and year (MMDDCCYY) format; note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year; Refer to specific instructions for field **24A**
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span
- A maximum of six line items per claim can be accepted; if the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements; total each claim separately
- Be sure to sign the form in the correct field; claims will be returned that are not signed unless EDS has a signature on file
- Do not use staples or paperclips for attachments; stack the attachments behind the claim
- Do not fold the claim form(s); mail flat in a large envelope (recommend 9 x 12)
- Only one PA number is allowed for paper claims
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim

3.22.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.22.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

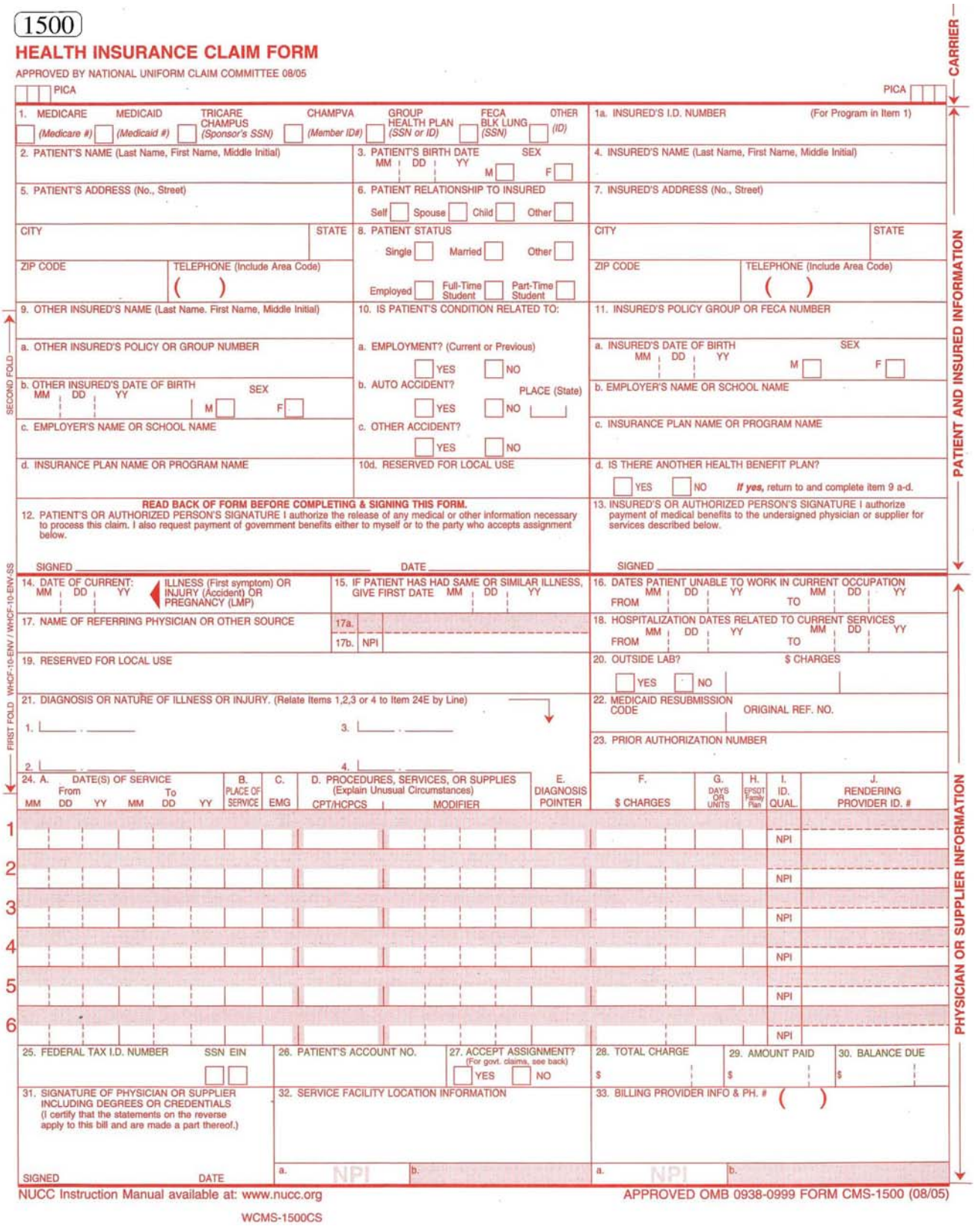
Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a-9d**.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	Other ID	Required if applicable	Use this field when billing for consultations or Healthy Connections participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For Healthy Connections participants, enter the qualifier **1D** followed by the 9-digit Healthy Connections referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI Number	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

Field	Field Name	Use	Directions
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24D 1	Procedure Code Number	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field **21**.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. Qualifier	Required if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID Number	Required if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID Number field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form,* for more information.
33	Provider Name and Address	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI Number	Desired but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.

Field	Field Name	Use	Directions
33B	Other ID	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.22.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS